Board of Trustees
State Health Plan for Teachers and State Employees
Department of State Treasurer
December 1, 2016

The meeting of the Board of Trustees of the North Carolina State Health Plan for Teachers and State Employees was called to order at approximately 4:00 p.m. on Thursday, December 1, 2016, at the Department of State Treasurer, 3200 Atlantic Avenue, Raleigh, NC 27604.

Members
Janet Cowell, Chair
Neal Alexander
Paul Cunningham, MD
Donald Martin
Warren Newton, MD
Elizabeth Poole
David Rubin

Participated via Phone
Margaret Way

Absent:
Andrew Heath
Aaron McKethan

State Health Plan and Department of State Treasurer Staff: Mona Moon, Lotta Crabtree, Caroline Smart, Nidu Menon, Lauren Wides, Mike Santos, Lucy Barreto, Mark Collins, Matthew Grabowski, Beth Horner, Lorraine Munk, Blake Thomas, Laura Rowe

Welcome

Janet Cowell, Chair, welcomed Board members, staff from the State Health Plan and Department of State Treasurer and visitors to the meeting.

Agenda Item – Conflict of Interest
Presented by Janet Cowell, Chair

In compliance with the requirements of Chapter 138A-15(e) of the State Government Ethics Act, Chair Cowell requested that members who have either an actual or perceived conflict of interest identify the conflict and refrain from discussion and voting in those matters as appropriate. Dr. Rubin and Ms. Way recused themselves from discussion regarding the Lake lawsuit. Dr. Martin noted, for the record, that he opted out of the Lake lawsuit and, therefore, wouldn't have a conflict of interest during those discussions.

Agenda Item – Review of Minutes (Attachment 1)
Presented by Janet Cowell, Chair

Following a motion by Dr. Cunningham and seconded by Dr. Newton, the Board unanimously approved the August 4-5, 2016, minutes, as written.

Agenda Item – Introductions (Attachment 2)
Presented by Mona M. Moon, Executive Administrator

Treasurer Cowell introduced new Board members, Dr. Donald Martin and Ms. Margaret Way. Ms. Moon introduced Dr. Patti Forest, State Health Plan Medical Director.

Agenda Item – Financial Report, Forecasting and Monitoring (Attachment 3)
Presented by Mark Collins, Financial Analyst

October 2016 Financial Report
Mr. Collins noted that a higher than expected membership increase accounted for the increase in Plan revenue. The October report followed a pattern similar to prior reports with the ending cash balance $222 million higher than the budgeted amount. Plan expenses were below projection and net income was higher than expected.

Medical utilization has remained relatively flat in recent years, while pharmacy expenditures demonstrate a slight but steady increase. Ms. Moon noted that the overall trend assumption may be a bit high, but breaking down the medical vs. pharmacy expenditures may provide a different story. In summary, the Plan's financials are currently outperforming the budget.

CY 2016 3rd Quarter Actuarial Forecast Update
Mr. Collins provided a presentation overview, noting that the CY 2016 3rd quarter forecast used a different comparison point than the previous Financial Report presentation. He also reviewed the revised 3rd quarter assumptions, noting that the quarterly rebate estimates were adjusted to reflect recent experience and the most recent guarantees under the new CVS Caremark contract. The higher than expected membership numbers resulted in a slightly higher revenue projection, while expenses are now expected to be slightly lower.

A review of the Plan's second quarter experience resulted in a projected decrease from 3.74% to 3.14% for the 2018-19 premium increases, which remain below the 4% target in the certified State Budget. The forecasted ending cash balance through June 2017 will not fall below the 12% legislative reserve floor for projected annual expenses.

2015 Lowest Cost Plan/Optimized Enrollment Analysis
The analysis conducted by the Segal Company to determine the lowest cost plan for each member was based on CY 2015 incurred claims. The report demonstrated that a majority of members would have been better off in the Consumer-Directed Health Plan (CDHP 85/15) but only 3% chose that option (up from 2% in 2014). While the final numbers for 2017 enrollment are not yet available, Ms. Moon stated that there was an increase in the CDHP membership in the current year.

Mr. Collins noted that the percent of members selecting the lowest cost plan increased in 2015 compared to 2014. The report analysis also demonstrated the potential member savings in moving from one plan to another.
Mr. Collins reviewed the key takeaways from the analysis, noting that the lowest cost plan option isn't necessarily the best option for every member. Some members may prefer a more consistent and predictable copay plan even if it is not the lowest cost option for them.

One Board member noted that the CDHP has been difficult to communicate and simplifying the communication may increase understanding. Another Board member stated that the enrollment process seemed smoother this year and looked forward to hearing more about the enrollment and

communication process. Ms. Moon stated that the Plan is working with staff inside the Department as well as an external group to develop a health literacy program. She also stated that the Plan would like the next generation of the health benefits estimator tool to include member access to their claims information.

Actuarial Valuation of Retired Employees' Health Benefits – Other Postemployment Benefits (OPEB) as of December 31, 2015

Mr. Collins began by reminding everyone that the State Health Plan Board is not responsible for the retiree health benefits liability, but can affect the liability through some of its decisions. He provided background information and reviewed the actuarial valuation process. He reiterated that while some of the Plan's programs can affect the unfunded liability, the Board doesn't have a responsibility for the results.

The current liability is $32 billion, an increase of approximately $6 billion from 2014. The largest portion of that increase is due to an experience study for the State Retirement System which impacted the retiree mortality expectations. Mr. Collins noted that the Board-approved benefit design changes and OPEB liabilities are not currently listed on the Plan's overall balance sheet but that is due to change in 2017-18. Ms. Moon noted that offering the Medicare Advantage options and taking advantage of the federal subsidies available helped to reduce Plan costs.

At this point, Chair Cowell reminded the Board members to complete their self-assessment in preparation for the December 20 meeting.

Agenda Item – Legislative Update (Attachment 4)

Presented by Matthew Grabowski, Health Policy Analyst and Legislative Liaison

Expansion of Local Government Participation

Mr. Grabowski provided an overview of the local government participation, stating that the enrollment cap through CY 2017 is 16,000 members. He reviewed the language and key provisions in Session Law (SL) 2015-112 and SL 2016-104, noting that current and future retirees are not eligible for coverage. The language also clarified that premiums collected by local government units had to conform to the Plan premium structure.

In response to a question regarding the financial impact on the Plan, Mr. Grabowski stated that the loss ratios for local units enrolled prior to 2016 were very near 1; this suggests that the financial impact of enrolling local units is negligible. The profile of most local government members is not much different than current Plan members.

The Plan is currently in the process of onboarding 11 local government units that will offer coverage effective January 1, 2017. A list of participating units was included in the Board material.

Transparency Workgroup Update

Mr. Grabowski reviewed the portion of SL 2013-382 which directed the Plan to establish a workgroup to examine the best way to provide Plan members greater transparency in the cost of health care services. The workgroup included active and retiree representation, as well as the provider community.

The Transparency Workgroup has met 1-2 times per year since early 2014, most recently meeting October 5, 2016. Mr. Grabowski noted key accomplishments by the workgroup and stated that next steps would include finalizing and submitting the 2016 Transparency Report to the Joint Legislative

Commission on Governmental Operations and the Joint Legislative Oversight Committee on Health and Human Services.

The legislative requirement to establish the workgroup and provide an annual report expires on December 31, 2016. However, the Plan is considering options to maintain or modify the workgroup to provide further insights on the development of transparency-related initiates.

Agenda Item – Contracting and Vendor Partnerships (Attachment 5)
Presented by Lauren Wides, Director of Contracting and Healthcare Compliance

Population Health Management Request for Proposal
Ms. Wides reviewed the benefits and services offered by the Plan's population health management vendor. The current contract with ActiveHealth Management expires in December 2017.

The Plan issued an RFP in August 2016 with two distinct scopes of work: Member Services and Supports and Worksite Supports and Services. The evaluation period by the Plan ended on November 15 and oral presentations are scheduled for December. The Plan will provide a recommendation to the Board at the January 2017 meeting.

Agenda Item – Executive Session

Pursuant to G.S. 143-318.11(a)(1) and (a)(3) and 132-1.9, Dr. Newton's motion to move into executive session was seconded by Ms. Poole and unanimously approved by the Board.

Consultation with Legal Counsel (*G.S. 143-(318.11(a)(1) and (a)(3))*
Presented by Heather Freeman, Attorney General's Office

Ms. Freeman discussed the legalities and the non-compliance impact of Affordable Care Act (ACA) Section 1557 requirements as they pertain to the Board of Trustees.

Due to the time, the Board decided to resume the discussion in executive session at 9:00 a.m. on Friday, December 2.

Lake Lawsuit Update (I. Beverly Lake et al. v. State Health Plan for Teachers and State Employees, et al.) *(G.S. §143.318.11(a)(3))*

This item was deferred to Friday, December 2.

Upon a motion by Ms. Poole and seconded by Dr. Cunningham, the Board voted unanimously to return to open session.

The meeting was adjourned at 6:30 p.m.

Board of Trustees
State Health Plan for Teachers and State Employees
Department of State Treasurer
December 2, 2016

The meeting of the Board of Trustees of the North Carolina State Health Plan for Teachers and State Employees was called to order at approximately 9:00 a.m. on Friday, December 2, 2016, at the Department of State Treasurer, 3200 Atlantic Avenue, Raleigh, NC 27604.

Members
Janet Cowell, Chair
Neal Alexander
Paul Cunningham, MD
Warren Newton, MD
Elizabeth Poole
David Rubin

Participated via Phone
Aaron McKethan
Margaret Way

Absent:
Andrew Heath

State Health Plan and Department of State Treasurer Staff: Mona Moon, Lotta Crabtree, Caroline Smart, Nidu Menon, Tom Friedman, Lauren Wides, Mike Santos, Mark Collins, Matthew Grabowski, Beth Horner, Lorraine Munk, Lucy Barreto, Fran Lawrence, Blake Thomas, Schorr Johnson, Brad Young, Laura Rowe, Kathryn Keogh, Jessica Pyjas

Welcome

Janet Cowell, Chair, welcomed Board members, staff from the State Health Plan and Department of State Treasurer and visitors to the meeting. She stated that the Board would return to executive session to continue the discussion from Thursday evening, December 1.

Upon a motion by Dr. Newton and seconded by Ms. Poole, the Board voted unanimously to return to executive session.
Upon a motion by Mr. Alexander and seconded by Ms. Poole, the Board voted unanimously to return to open session at 11:10 a.m.

Agenda Item – Conflict of Interest
Presented by Janet Cowell, Chair

In compliance with the requirements of Chapter 138A-15(e) of the State Government Ethics Act, Chair Cowell requested that members who have either an actual or perceived conflict of interest identify the conflict and refrain from discussion and voting in those matters as appropriate. No conflict was noted.

Agenda Item – Benefit Design, Plan Options and Premiums (Attachment 6)

Chair Cowell announced that the discussion would begin with Item 3.a.ii.

Recommended Benefit Changes for CY 2017

ACA Section 1557 Requirements – Coverage for Gender Dysphoria

Gender Dysphoria Condition and Treatment
Presented by Patti Forest, MD, State Health Plan Medical Director

Dr. Forest began by discussing the gender dysphoria diagnostic criteria and standards of care. The criteria for gender confirmation surgery was presented, with Dr. Forest noting that candidates for surgery must complete a minimum of 12 continuous months of real life experience in their new gender with no returning to their original gender.

The American Medical Association Resolution 122 issued in 2008 removes the financial barriers of care for transgender patients. The American College of Physicians and American College of Obstetricians and Gynecologists Committee have also endorsed coverage for transgender health care services.

Overview of Legal and Compliance Risks
Presented by Ashley Gillihan, Alston & Byrd, LLP, (via phone)

Mr. Gillihan, attorney with Alston & Byrd, introduced himself, stating that he has provided outside legal counsel to the Plan regarding the ACA for the past three years. His area of expertise is employee health benefits.

The Plan receives federal funds from the Retiree Drug Subsidy (RDS) and currently excludes coverage for the treatment of gender dysphoria. Section 1557 prohibits discriminating based on race, color, national origin, sex, age or disability. If the Plan continues to receive federal funding without including coverage for the treatment of gender dysphoria, the Plan will be considered non-compliant as of January 1, 2017. This could result in the suspension or termination of the RDS funding and/or the possibility of civil action by someone challenging the violation.

Proposed Benefit Change
Presented by Lotta Crabtree, Deputy Executive Administrator and Legal Counsel

Ms. Crabtree briefly reviewed the Section 1557 requirements, risks of non-compliance and protections under the rule. She stated that the Plan has already completed procedural requirements regarding a grievance procedure and taglines in communication material addressing individuals with limited English proficiency. The final rule does not define the coverage of specific services, but does make clear that denying coverage of transition-related services would be subject to "careful scrutiny."

A state-by-state response to Section 1557 and a summary of compliance and discrimination laws were provided to the Board. Ms. Crabtree noted that the Plan has submitted a request for RDS funding each month in 2016.

In response to a question regarding the State 's Medicare and Medicaid policies, Ms. Crabtree stated that while a medical policy is not in place, limited coverage is provided on a case-by-case basis and there are no categorical exclusions of which she is aware.

The Plan's current benefit provides blanket exclusions for the treatment of gender dysphoria, including treatment or studies regarding sex changes or modifications, psychological assessments and psychotherapy treatment. The annual cost of coverage provided by the Plan's actuarial consultant is approximately $350,000 to $850,000.

If the Plan were to provide coverage for transgender dysphoria services, utilization management policies would apply to transition surgery and hormone therapy. The Plan would adopt the Blue Cross and Blue Shield of North Carolina (BCBSNC) medical policy, included in the Board material, which includes the requirements in support of medical necessity.

Several states and health care providers filed a lawsuit against the Obama administration seeking to block a portion of Section 1557. The Attorney General's Office and the Office of the Governor would need to provide consultation or make the decision as to whether or not the Plan could join the lawsuit. The Plan recommends approval of coverage for the treatment for gender dysphoria by removing the blanket exclusions resulting in the provision of medically necessary services for the treatment of gender dysphoria.

Member and Public Comment Period
TBA

Ms. Jeanne Duwve and her son, Luke, both members of the Plan, relayed the story of her son's life and what it means to be transgender. She thanked the Board for their consideration in removing the exclusions for the treatment of gender dysphoria.

Ms. Patti Adams, a clinical social worker, stated that she is not eligible for state benefits, but has had the opportunity to work with adolescents and adults contemplating gender transformation. She discussed the mental health aspects of gender dysphoria and stated that the decisions for some people can be a matter of life and death. She also thanked the Board for considering the benefit change.

Board Discussion and Vote
Dr. Cunningham made a motion recommending that the State Health Plan removes the blanket exclusions that relate to treatment or studies leading to or in connection with sex changes or modifications and related care, and psychological assessment and psychotherapy treatment in conjunction with proposed gender transformation, resulting in the provision of medically necessary services for the treatment of gender dysphoria. This implies that the third-party administrator, Blue Cross and Blue Shield, will utilize the existing approach to administrating this issue. Separately, the State Health Plan will communicate with the Attorney General's Office to fully explore any of the residual issues that may be relevant to this.

Dr. Rubin seconded the motion. Chair Cowell opened the floor for discussion.

Mr. Alexander made a motion to defer the decision until the January Board meeting. Mr. Thomas replied that a vote could not be deferred beyond the next regularly scheduled meeting, which is December 20, 2016.

The question was asked if a motion could be made to lay the original motion by Dr. Cunningham on the table. A yes vote would allow the Board to take other action. Such motion was made by Mr. Alexander and seconded by Donald Martin. Mr. Alexander, Dr. Martin, Dr. McKethan and Ms. Way voted yes. Dr.

Cunningham, Dr. Newton, Dr. Rubin and Ms. Poole voted no. Chair Cowell broke the tie and voted not to table the motion.

Chair Cowell stated that the Board could now further discuss and debate the original motion by Dr. Cunningham.

Dr. McKethan offered a resolution to Dr. Cunningham's original motion, stating that "with this resolution, the Board intends to ensure that the State Health Plan follows all applicable laws and regulations, but recognizes that the validity of the federal regulation and interpretation of related laws are currently the subject of litigation and may change over time. Therefore, the Board intends for this resolution to apply to the 2017 plan year. It will be revisited in advance of the 2018 plan year.

Dr. Rubin asked a procedural question as to whether Dr. McKethan's resolution could be accepted as a friendly amendment to the original motion. Following consultation with legal counsel, Dr. Cunningham agreed to accept Dr. McKethan's resolution as a friendly amendment to his original motion.

Chair Cowell stated that the removal of the blanket exclusion for benefit year 2017, with the Board to revisit the benefit change for the 2018 benefit year, was now on the table for a vote.
The vote to approve the original motion with the friendly amendment passed unanimously, with one board member, Neal Alexander, abstaining.

Following the vote, a Board member requested the vote and amendment verbiage, in writing, prior to the end of the Board meeting.

Mr. Blake Thomas, General Counsel for the State Treasurer, agreed to provide the verbiage, in writing, before the Board adjourned.

<u>Coverage of Short-Term Rehabilitative Therapies under the CDHP</u>
Presented by Lotta Crabtree, Deputy Executive Administrator and Legal Counsel

During the Public Comment Period at the August Board of Trustees meeting, a Plan member asked the Board to consider a benefit change to the combined maximum number of physical therapy (PT), occupational therapy (OT), and chiropractic visits allowed in a benefit year. She and other Plan members have conditions and circumstances that may require more than the 30 visits allowed.

Ms. Crabtree reviewed the utilization for these services in 2015 and stated that the cost to make the benefit change would be approximately $137,000, since only a small portion of the Plan's membership would be impacted.

Mr. Alexander made a motion, which was seconded by Dr. Newton. The Board unanimously voted to approve the staff recommendation to remove the combined 30-visit limit on PT, OT and chiropractic care services, as well as to remove the 30-visit limit on speech therapy and to place a 30-visit limit on chiropractic care under the CDHP plan option.

With this change, the coverage under the CDHP will align with the current coverage under the 80/20 and 70/30 plans.

In response to a question regarding where the 30-visit maximum originated, Ms. Crabtree stated that it was industry standard.

2018 Benefit Development

Stork Rewards Program
Presented by Jessica Pyjas, Health Promotion and Wellness Coordinator

Ms. Pyjas provided an overview, history and goals of the Stork Rewards program launched in October 2011. She reviewed the incentives under each plan option and the engagement outcomes in the past four years. The program has had a positive impact on the overall engagement for medium and high risk members. The program modification in 2014, requiring members to enroll by their 13th week of pregnancy, resulted in an increase of engagement early in the pregnancy.

One Board member commented that the program costs per year seemed very high. Ms. Pyjas stated that the cost of the program was covered, for the most part, by the annual Per Member Per Month (PMPM) that is paid to the Population Health Management Vendor. The incentive payment is over and above this payment.

The Return on Investment (ROI) was based on avoided adverse events, such as antenatal complications, preterm birth, low birth weight and pre-term with low birth weight newborns. Ms. Pyjas noted that the Plan members have a lower rate of preterm births compared to the state rate.

The Plan is considering the phase-out of the Stork Rewards incentive program in 2017 but will continue to offer maternity coaching without the incentives in 2018. Enrollment into the program would be discontinued after March 31, 2017. Phasing out the Storks Reward program would require Board approval, followed by the development of a communication plan. A board member suggested keeping the program but reducing the incentive.

In order to improve the health of our members, one Board member suggested that perhaps the Plan could incent parental group visits to reduce the preterm labor rate. Another suggestion was for the Plan to consider not paying for C-sections prior to 37 weeks unless medically indicated.

Another Board member noted that after the first year, the ROI wasn't significantly different. Another member noted the modest cost increase in year 4 but the savings in that year dropped rather significantly. In that same year, member engagement decreased somewhat, but the number of women who completed the program dropped significantly. Another member requested more details regarding the sources of savings and what, specifically, was prevented by those who participated in the program. One Board member felt that the Plan needed to determine why members weren't finishing the program and urged Plan staff not to drop the program altogether.

Chair Cowell acknowledged the thoughtful questions and stated that the program would be further discussed at the January meeting. Ms. Moon asked the Board members to consider revisions in response to the questions and comments raised and share them with her. Plan staff will discuss potential changes and present them to the Board in January.

Strategy and Potential Benefit Changes
Presented by Mona M. Moon, Executive Administrator; Patti Forest, MD, Medical Director; Caroline Smart, Chief Operating Officer; Nidu Menon, Director of Integrated Health Management

The 2018 potential benefit design changes have been developed based on the strategic plan that was revised and approved at the August Board meeting. The legislative mandate to keep the employer contribution less than 4% in 2018 and 2019 gives the Board a chance to enhance and change some

things to further the mission of the Plan, given that the updated baseline forecast projects a required premium increase of 3.14%.

Ms. Moon reviewed a summary of the benefit changes under consideration for each plan option. One of the benefit enhancements would be to incent the use of Blue Distinction Centers. These are nationally designated treatment facilities recognized for providing specialty care for certain procedures. The Plan has used Blue Designated Providers for bariatric surgery, which has worked very well.

If the current healthy activities are maintained, the value of the credits would increase in the CDHP and Enhanced 80/20 Plan. The result would be a premium increase of 3.14% in 2018 and 2019. If the tobacco attestation was the only healthy activity maintained, the premium increase would be 3.69%.

Dr. Forest stated that diabetes remains one of the most prevalent chronic conditions of Plan members. Diabetes has an impact on overall health, as well as a significant financial impact. In 2015, active members and non-Medicare retirees with diabetes incurred approximately $400 million in allowed claims. The Plan offers tools and resources to assist members in managing diabetes and the Board approved a diabetic drug tier in the Enhanced 80/20 and Traditional 70/30 plans for 2017.

In response to a question as to whether the Plan could focus on incenting medications that help people live longer, Dr. Forest stated that some of the generic drugs in that category are very low cost.

A Board member suggested that selecting a Primary Care Provider (PCP) is a very important piece in the coordination of care and that it appears that a lot of members don't have a regular provider. The validity of the health assessment was also questioned. Dr. Menon stated that the health assessment helps to identify members "at risk" who would not present themselves through the medical claims data. The Plan is also preparing a detailed analysis of three years of health assessment data to present to the Board. She further stated that the Plan isn't abandoning the health assessment but is trying to determine how to incorporate it into other plan benefits such as the Health Engagement Program.

In response to another question regarding whether the tobacco attestation has reduced the number of smokers, Dr. Menon stated that the attestation by itself was not intended to reduce the number of smokers but to identify smokers and ensure that they have access to the resources that will assist them in their effort to quit smoking.

Dr. Forest stated that the Plan has considered expanding the diabetic pharmacy tier or creating a new one for preferred insulin. Over the next month, staff will also discuss the possibility of reducing the coinsurance on the CDHP since many medications are already deductible exempt. A suggestion was also made to consider the cost of diabetic test strips.

As the plan design is structured for diabetes care, the Plan will share the information with the Board. Dr. Menon reviewed information on the Health Engagement Program (HEP). The Healthy Lifestyles enrollment continues to grow and currently totals 3,153 members. The enrollment in the Positive Pursuits program has also seen a steady growth since its launch in April.

The Plan would like the Board to consider expanding the Positive Pursuits program to members in the 80/20 Plan. Dr. Menon reviewed the reasons for expansion, one of them being that there are more members with chronic conditions in the 80/20 Plan rather than the CDHP. Staff recommends further experience with the Healthy Lifestyles program before expanding it to the 80/20 Plan. This is a different approach from what was presented at the August Board meeting.

The guiding principles for expansion and incentives were briefly summarized. Dr. Menon stated that incentives for the Positive Pursuits program would require more thought and discussion. The Plan eventually wants to move in the direction of incrementally expanding this program.

Ms. Moon stated that staff is interested in what the Board thinks regarding incentives and what would work best to change behavior. In response to a question regarding focus groups to determine what members want, Ms. Horner stated that the Plan has conducted focus groups regarding benefit options but not incentives specifically. A suggestion was made to survey CDHP members to determine what motivates them to engage and what incentives work.

Another suggestion by a Board member was to discuss the types of data and experience BCBSNC has on other groups they cover. Learning what has worked for other group members and lessons learned might provide valuable feedback for the Plan. Ms. Moon stated that discussions with Plan vendors and in-house data modeling is incorporated in program development. A request was made to share that data with the Board.

Mr. Collins discussed the potential of establishing a base premium on all plans in order to spread the risk across the membership. He also reviewed the premium increases required for 2018 and 2019 if dependent premiums were frozen.

Mr. Collins presented three options for the 70/30 Plan, along with the medical and pharmacy plan design under each option. He noted that the Plan recommends at some point to take steps to realign the pharmacy benefit in the 70/30 and 80/20 plans and determine whether or not to give up Grandfather Status.

Ms. Moon stated that prior to the February 10, 2017, vote on the 2018 benefit design, she would share information with the Board via email and workgroup calls. The benefit design will be shared with the Board at the January 26-27, 2017, meeting.

<u>Reconsideration of Motion in re Section 1557 of the ACA</u>
At this point in the meeting, Mr. Thomas provided the Board with the written verbiage of the earlier motion. The Board agreed that the language provided did not match what they thought they had approved. After a motion to reconsider by Paul Cunningham, seconded by David Rubin, which was approved unanimously, the language for the motion was revised. There was then a motion to approve the amended language by Warren Newton, seconded by Liz Poole. The motion carried unanimously by those voting, 6-0. Neal Alexander abstained from the vote and Dr. McKethan was not present.
The final benefit approval is as follows:

> "The NC State Health Plan removes the blanket exclusions that relate to treatment or studies leading to or in connection with sex changes or modifications and related care; and psychological assessment and psychotherapy treatment in conjunction with proposed gender transformation; resulting in the provision of medically necessary services for the treatment of gender dysphoria. This infers that the third-party administrator – Blue Cross Blue Shield - will utilize the existing approach to administrating this issue."
>
> "Separately, the State Health Plan will communicate with the Attorney General's Office to fully explore any of the residual issues that may be relevant to this."

"With this resolution, the Board intends to ensure that the State Health Plan follows all applicable laws and regulations, but recognizes that the validity of the Federal Regulation and interpretation of related laws are currently the subject of litigation and may change over time. Therefore, the Board intends for this resolution to apply to the 2017 plan year. It will be revisited in advance of the 2018 plan year."

Agenda Item – Member Experience and Communications (Attachment 7)
Presented by Beth Horner, Customer Experience Manager, and Caroline Smart, Chief Operating Officer

Open Enrollment Communications and Results
In the interest of time, Ms. Horner and Ms. Smart provided a high level summary of the presentations. The enrollment period was extended from October 31 to November 5, 2016, to allow for those affected by Hurricane Matthew to complete their enrollment.

Ms. Horner reviewed the HBR training efforts, member outreach events and the resources and tools that were in place to assist members with their Open Enrollment selection. Ms. Smart reviewed the actual enrollment results with the Board. Website statistics indicated that 366,000 new users accessed the Plan's website. At the end of the Open Enrollment period, a total of 401,088 subscribers completed enrollment.

The tobacco attestation rate improved over last year, with members in the 70/30 Plan having a chance to complete the attestation for the first time during Open Enrollment. Members who agreed to enroll in QuitlineNC have until the end of the year to do so. Ms. Smart also noted that more members completed the health assessment this year compared to October 2015.

Enrollment in the CDHP for non-Medicare subscribers increased significantly this year with 23,399 enrolling in this plan option, compared to approximately 14,000 last year. Sixty-three percent of the Medicare primary subscribers remained in the Traditional 70/30 Plan. Termination letters were sent to members who are currently enrolled in Humana, which has generated a significant number of phone calls to Benefitfocus and Humana. Overall, the enrollment process went well, with minimal technical barriers.

The full report from the telephone town hall meetings was included in the Board material.

CVS Implementation and Communication Outreach
Plan staff have been working with CVS Caremark over the past months to prepare for the January 1, 2017, effective date. Over the next few weeks, final testing, member notification letters and ID cards will be finalized and completed.

Communication materials have been sent to members and providers and CVS will send a communication blast to pharmacies in December. Information has also been posted on the Plan's website. In response to a question regarding the exception process effective date of January 1, Ms. Horner stated the Plan has communicated the importance of planning ahead to both members and providers.

2016 Membership Satisfaction Survey Results
Approximately 2% of subscribers and covered spouses responded to the satisfaction survey, an increase from last year's survey. Ms. Horner reviewed highlights in the executive summary, noting that 36% and 33% of active/non-Medicare and Medicare retiree members, respectively, would likely benefit from a smartphone app to assist them in better understanding their health benefits.

The overall satisfaction with the Plan is not as high as the Plan would like. Ms. Horner stated that the next survey may delve a bit deeper into this question to learn specifically what might be driving the dissatisfaction. It was noted that the 2015-16 survey results were compared to 2012, since this question wasn't asked in the 2014 survey. The survey details were included in the Board material.

2017 Communication and Marketing Strategy

As the Plan strives to engage members and increase their health plan literacy, efforts will focus on several programs and initiatives in 2017. Webinars have gained in popularity over the past year and the Plan will continue to offer them on a variety of topics. The Plan will also increase educational efforts regarding Blue Option Designated Providers. With the growing membership in the CDHP, direct mailers will be sent and webinars offered in January to remind members how the plan works.

In response to a question as to whether the Plan can link data with members who have saved money in order to target educational efforts to members not in the CDHP, Ms. Moon stated that the Plan would discuss it with Segal. She further noted that the Plan continues to look at ways to enhance member education and welcomes suggestions.

Another Board member asked if the health benefit estimator could include a member's out-of-pocket expenditures for the previous year. Ms. Moon stated that while that feature is not currently available, the Plan would like a link to a member's claims data in the next generation of the tool.

Due to time constraints, the Clinical and Program Operations items were deferred to the December 20, 2016, meeting.

Following a motion by Dr. Newton and seconded by Mr. Alexander, the Board voted unanimously to adjourn at approximately 3:00 p.m.

Janet Cowell

Janet Cowell, Chair